SHPA

Rebuild, Renew, Revitalize!

Core Competencies Toward Resilient Services Series

Workshop 4

Housing First

An Overview

October 28th, 2021

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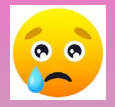
Heartland Alliance Health

Midwest Harm Reduction Institute

Heartland Center for Systems Change

My apology … two big apologies

- Today's presentation will largely be technical – as if one were undergoing a fidelity review for Housing First … and being dual-diagnosis treatment capable
- Self-assessment of current program, thinking ahead, strategic planning
- Not so much how to operate a housing program
- Everyone's situation so unique including funding, community
- Separate trainings … housing locators, landlord partnerships, eviction prevention
- This will be HF as the EBP
- Still … encourage discussion, chat .. as this is also about HOW YOU FEEL & THINK about doing Housing First
- Very few pictures or diagrams … a LOT of words  **a PDF manual**
- Each time, I go back and redo so hope to add those for the future … for today, I'm so sorry! 

A quick introductory overview review of Workshops 1 - 3

Objectives:

- Be able to describe the core principles and values of Housing First
- Increase integration of person centered, trauma aware, harm reduction, motivational interviewing approach with HF EBP
- Identify components of a co-occurring treatment program
- Have outlines for strategic planning – program development / enhancement


Do The Best You Can
Until You Know Better
Then When You Know Better
Do Better
- Maya Angelou -

At the Heart of Our Work

- When we begin with a **PERSON CENTERED** foundation
- Then we know people have lives with **TRAUMA**
- And if we are to respond to trauma with care & healing,

HARM REDUCTION will be indispensable

- And to facilitate these, **MOTIVATIONAL INTERVIEWING** becomes our partnering conversation style

- inner voice inner guide thread -

Housing First

is embedded within …

a PERSON CENTERED foundation

with TRAUMA AWARENESS

using

HARM REDUCTION

and

MOTIVATIONAL INTERVIEWING

❖ a PERSON CENTERED foundation

Is to hold the belief …

- **Every one has within them an inner voice, an internal guide, an internal compass** which becomes distorted, buried, forgotten, hidden, distanced from during life, *traumatized*
- Every **recovery encounter** reflects ***"something within me came to life when I met this person"***
- Internal guide reconnected with because of a relationship
- What it means to "believe in" the person and be grounded in their unique lived experience

Person Centered Trauma Aware

- Our task is to support and affirm their hearing this internal guide of theirs, becoming familiar with it and comfortable with its direction. Encouraging use of their power toward this. There are practices we can employ which nurtures the likelihood of this unfolding.
- Conversely, spirit breaking and dishonoring the will of another is to contribute significant long term harm.
- And to not replace their inner voice & guide with our own

HARM REDUCTION AS A RELATIONSHIP

Our establishing a relationship of collaboration and partnership *is* itself harm reduction.

A primary element of harm reduction is the individual accepting this relationship with our *shaping it to that acceptance and invitation.*

Without this we're not exercising harm reduction more than we are

control = power struggles

- ***Motivational Interviewing*** **as a way of *listening* for, *reflecting* back, *strengthening* awareness and a tie in to a participant's internal voice & guide**

- **A specific way of *structuring a supportive conversation***

Our 4 Core Competencies

- PERSON CENTERED
- TRAUMA INFORMED CARE
- HARM REDUCTION
- MOTIVATIONAL INTERVIEWING

Interrelated, intuitively flow from each other and are integrated –
Pull on one and the rest follow

ONE INTERRELATED INTEGRATED THOUGHT SYSTEM

Not limited to work – truly life skills and approaches

Every task, every job, has a set of tools.
You your *self* is the tool for this work.

HOW WE BUILD **RELATIONSHIPS**

YOU 😍

how you wrap your gift

HOW DO YOU **ENGAGE?**

1 Hint: provide something meaningful, tangible, wanted, to the person

ENGAGEMENT

Appearance & First Impressions

Authenticity

Being fully present

Being liked/respected and the power of influence

Credibility

Consistency – with every participant, every staff, all the time

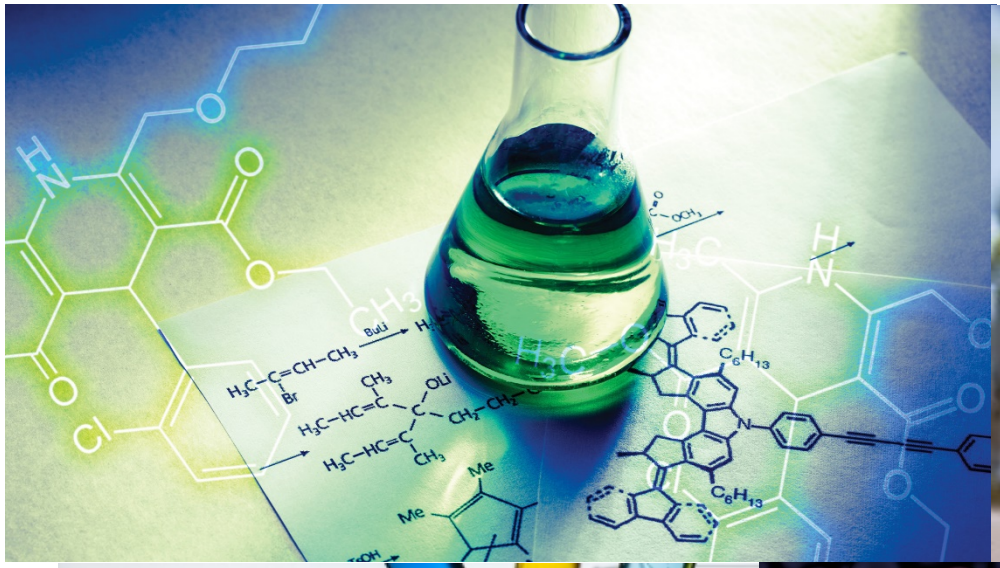
ACTING ON CORE VALUES

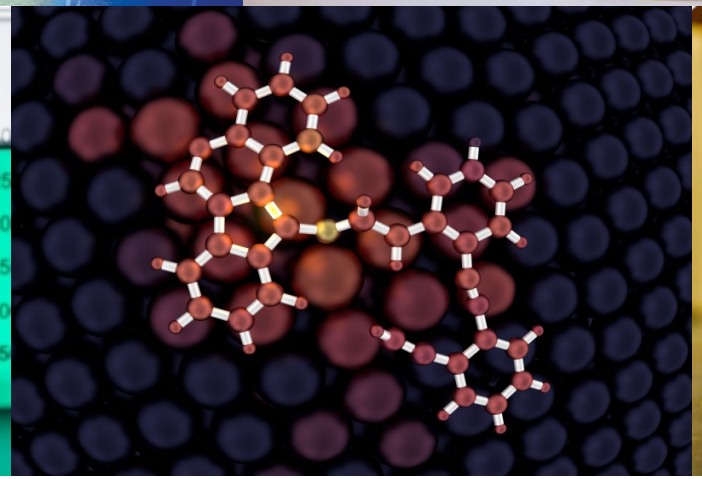
Person Centered: Inner Voice, Internal Guide

A TOOL WITH A PURPOSE

The Centrality of Relationship

Our **relationships** produce a **chemical reaction**





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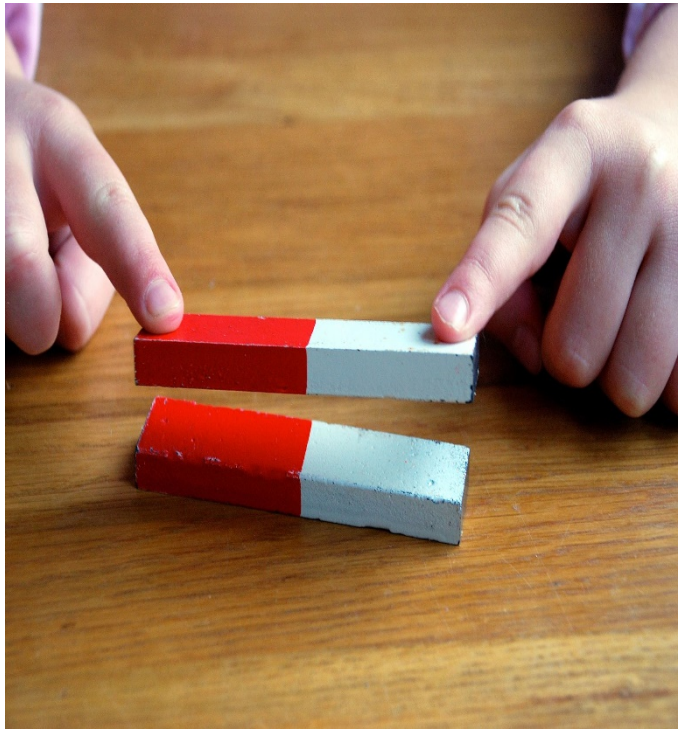
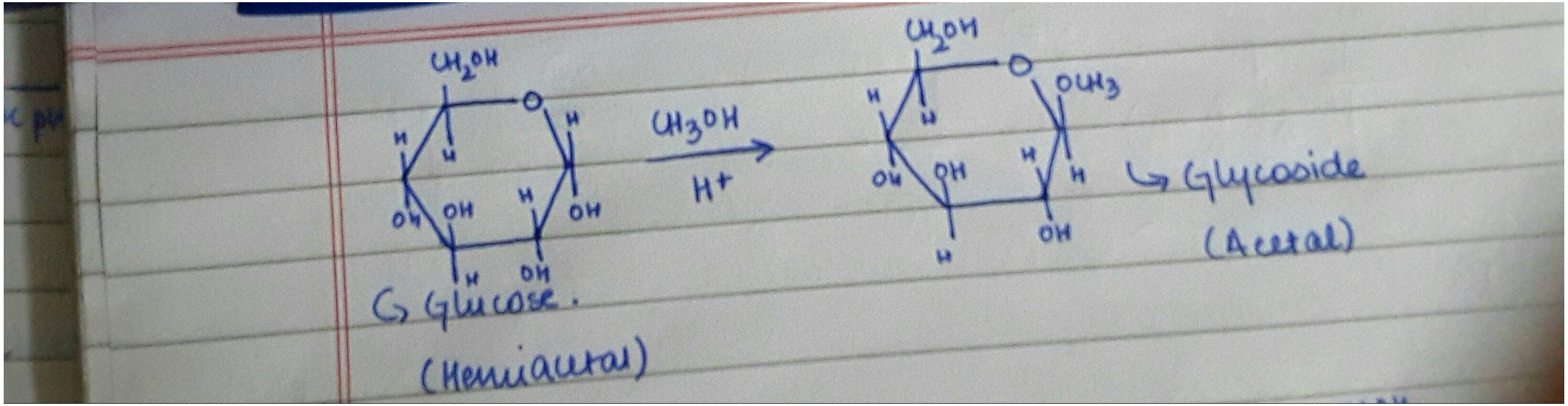
There's a **magnetism** in our relationships.
This can draw us in or push us away from each other.



We want to be intentional, mindful to move the interactive reaction in the desired direction



The work of healing

Framed as the art & science of making sandwiches

FOUNDATION SLICE

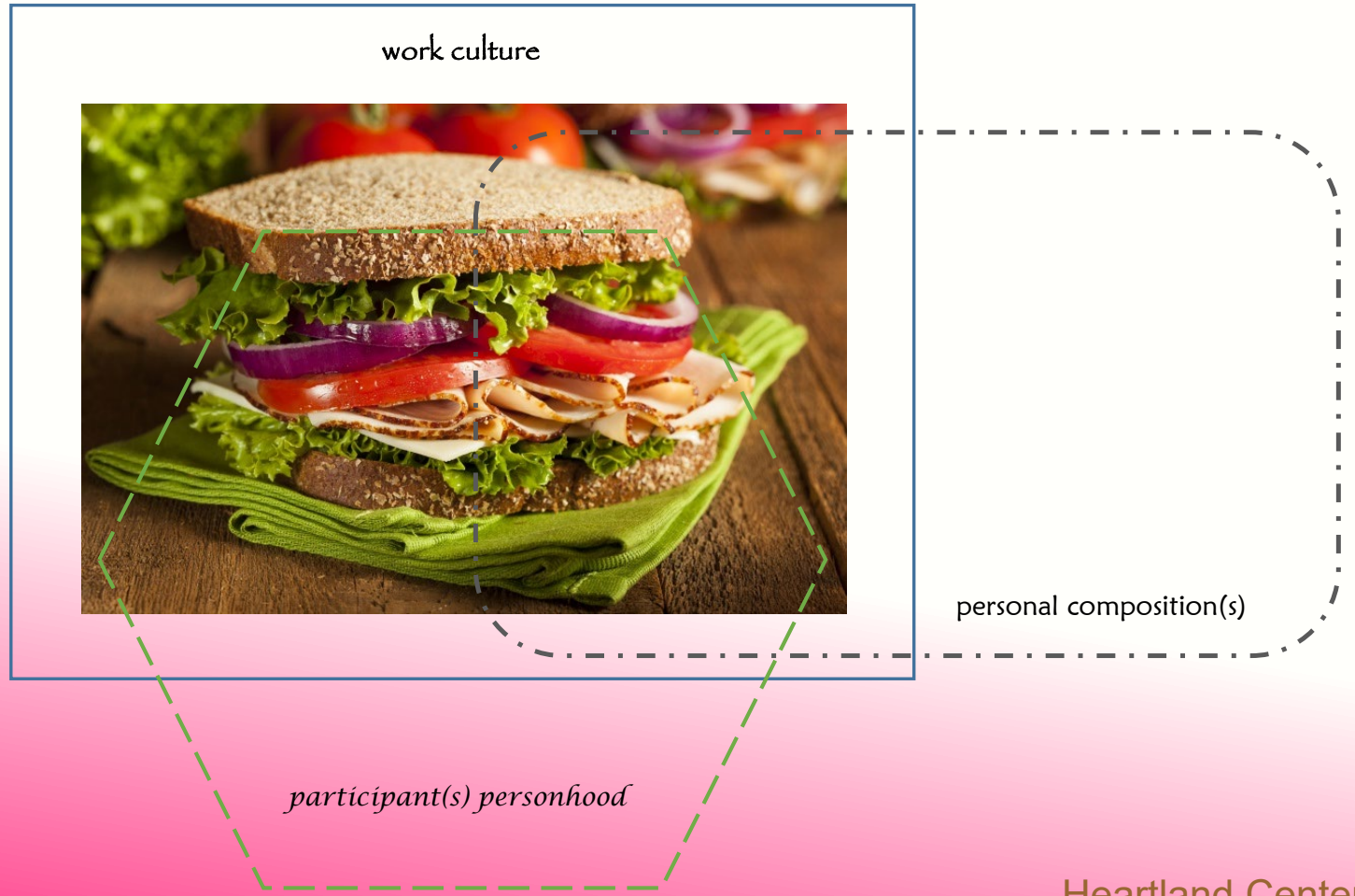
Staff: YOU!

What type of bread?

Qualities of a strong slice upon which to build

the complexity of the kitchen

our work culture



What else do we need to be successful?

- **Self-reflection**: self-awareness and sensitivity to those around us
- **Empathy**: being present and caring
- **Welcome feedback** & input on how we're doing and build on that

- **Work Culture:** **mutual** *respect*, **mutual** *trust*, **mutual** *accountability*
- **Personal Qualities:** *personal integrity*, act with *intelligence* (the ability to think through a process, connect dots with understanding in a progressive positive way, and present a pathway toward a desired outcome, and to make adjustments as new information is received), and *active level of energy*.

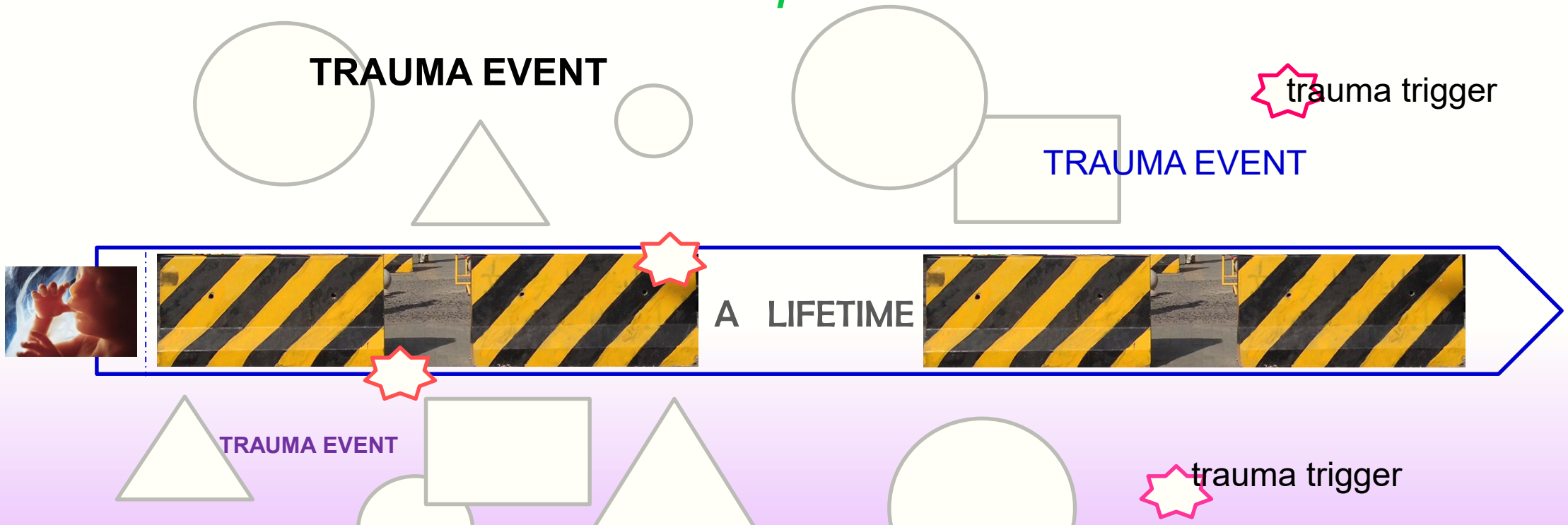
THE *KEY* *INGREDIENT is*

the quality of our relationships

The most valued ability & skill then is that of engaging, building, sustaining and nurturing relationships in which people thrive.

Conversely, spirit breaking and dishonoring the will of another is to reinforce trauma, promote fear and defenses.

LIVES WITH TRAUMA *disruption to internal voice*



TRAUMA TEACHES US TO DEFEND & PROTECT OURSELVES
AND BE MISTRUSTFUL OF OTHERS AND THE WORLD
Life as frequently or constantly threatening
Be on guard
Self-preservation (power, control, energy)

TRAUMA ARMOR & DEFENSES

Traumatic events

- We find a way to defend and take care of ourselves
- Impact our brain and thinking/feeling/reacting functions

What trauma armor & defenses do you see? in yourself & others

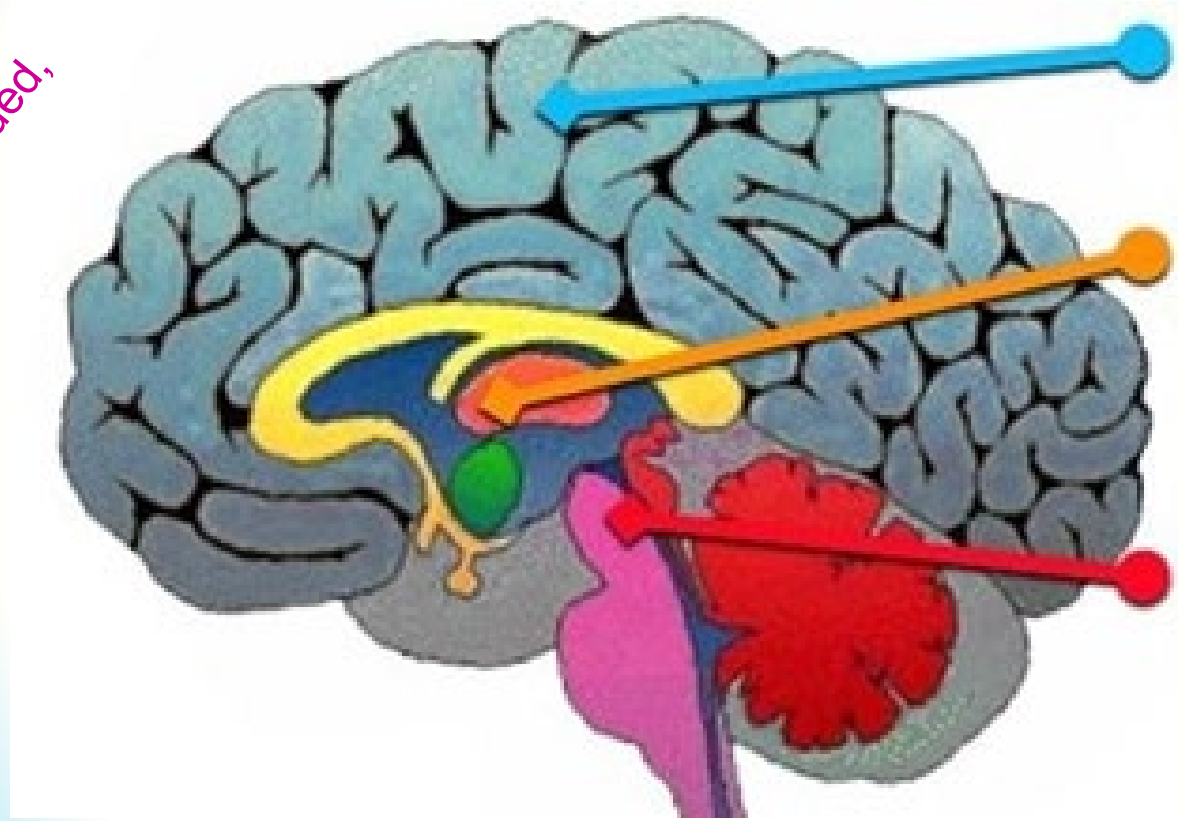
- Motivational Interviewing as also listening for a way to become self-actualizing over self-preservation; how to be vulnerable, to find new ways of using strength

OS NEUROPLASTICITY & TRAUMA WORK: The Goal – new neural pathway responses

Between stimulus and response, rather than reactive, **build in a pause**

For the prefrontal cortex thinking brain to begin moderating the primitive brain reactivity

Safe, connected, valued, hold significance



NEOCORTEX
reason

LIMBIC
emotion

REPTILIAN
instinct, survival

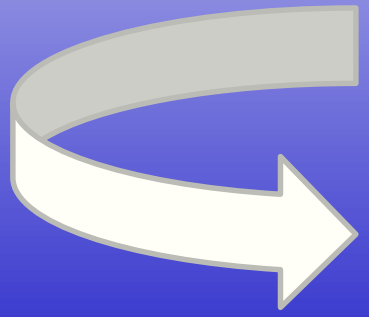
- **Fight**
- **Flight**
- **Feed**
- **Breed**

neuroplasticity

- **Kindness and acceptance literally rewire the brain**
- Over time, it takes the responses down different neural pathways than the usual automatic route and response
- Releases different neurotransmitters
- Conversely being critical, shaming/blaming, disliking reinforces that perceived threat and strengthens the usual route and response (cholesterol study example)

Trauma Targets Ones Use of Power

- Self-preservation
- Self-defense
- Self-care
- Threat, Fear, Pain & Suffering reduction, internal and external
- Survive



Transform to Thriving, Self-Actualizing *(How?)*

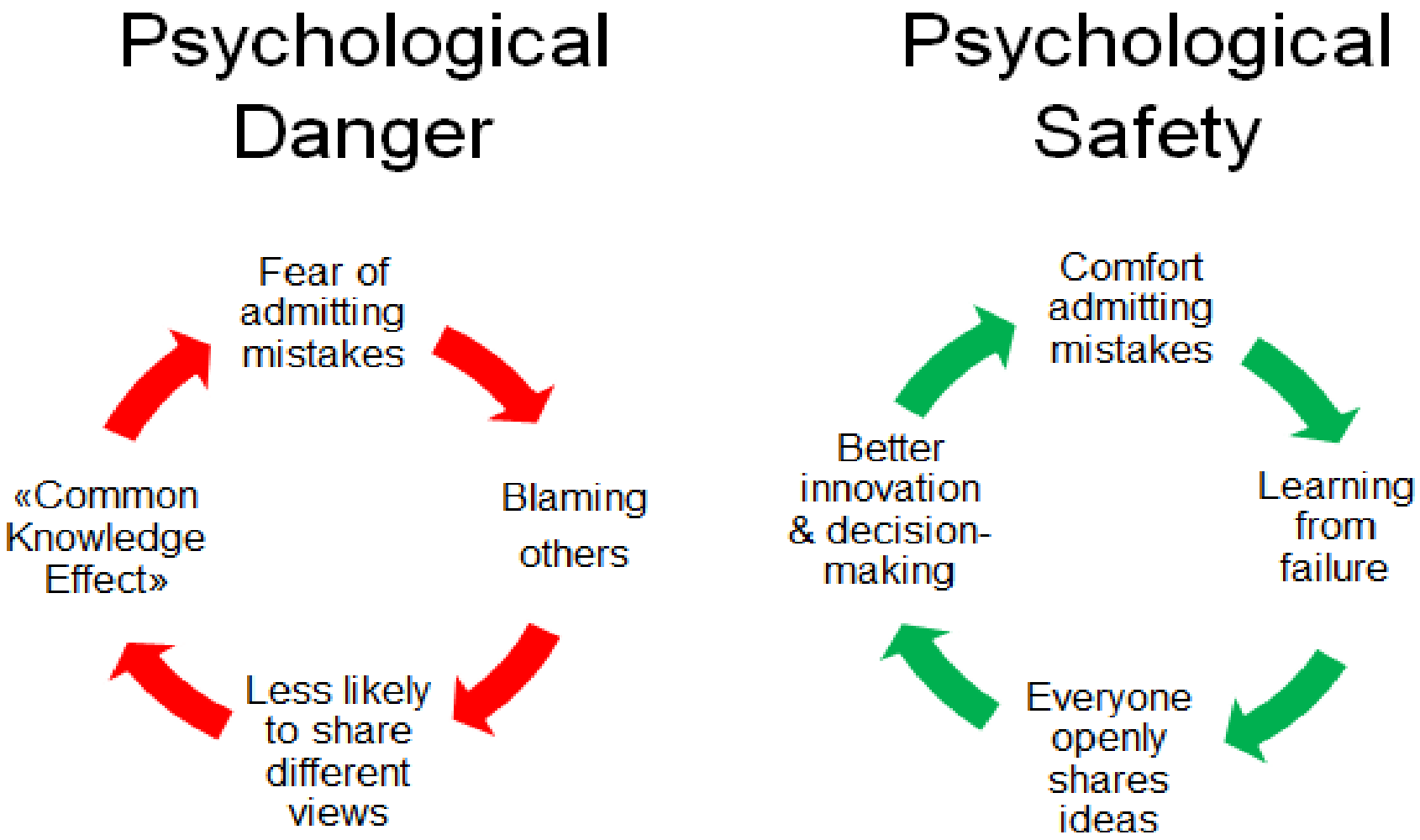
TRAUMA AWARENESS

❖ POWER DYNAMICS

- Trauma is power related
- The relational structure of staff to participant
- Supervisor to supervisee
- Pre-set trauma trigger
- Habitual protective reactions (self-care)

❖ THE PROCESS OF HEALING

- Trauma healing stages are also trauma triggers
- Healing is more difficult than remaining defended
- Kindness over time can lower defenses which becomes vulnerability
- The very healing process ‘relives’ trauma
- Pre-set trauma triggers



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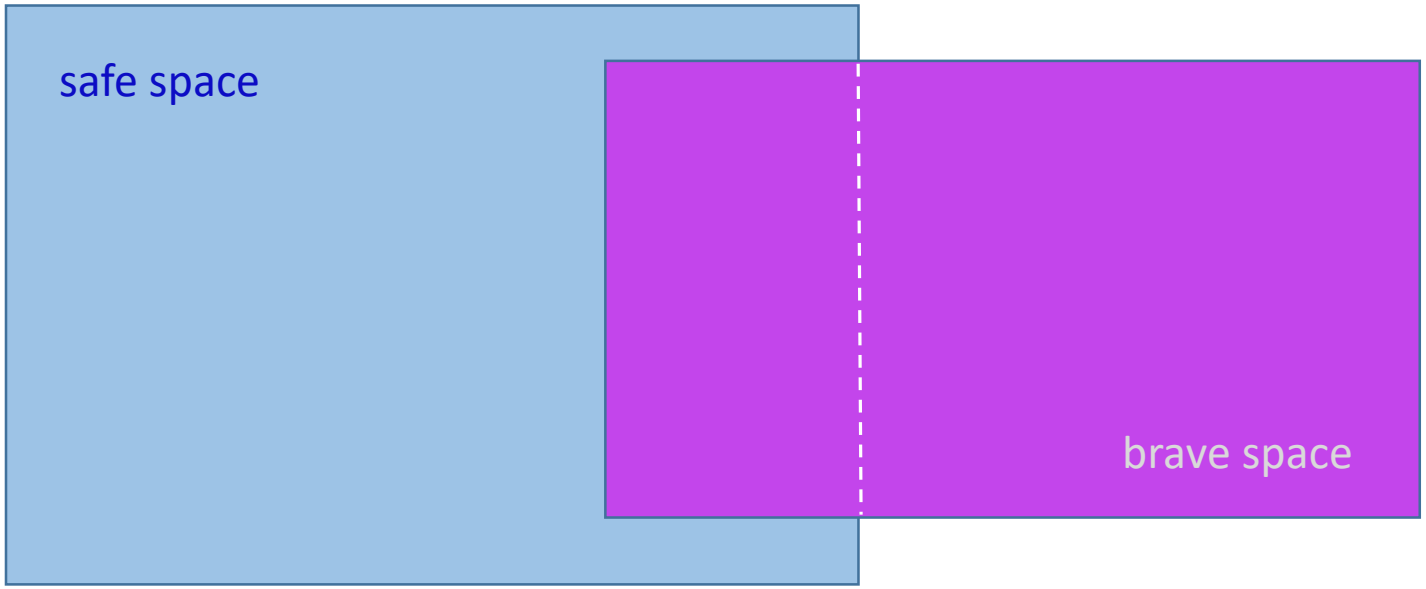
safe space brave space fluidity:
the growth zone



Safe space allows and supports the courage to try brave new ways

- Internalize this over time -

WORDS MATTER the power of position, of judgments, & response *AND* the words we choose and use

WORDS ARE SINGULARLY THE MOST POWERFUL FORCE AVAILABLE TO HUMANITY.

WE CAN CHOOSE TO USE THIS FORCE CONSTRUCTIVELY WITH WORDS OF ENCOURAGEMENT,
OR DESTRUCTIVELY USING WORDS OF DESPAIR.

WORDS HAVE ENERGY AND POWER WITH THE ABILITY TO HELP, TO HEAL, TO HINDER, TO HURT, TO HARM, TO HUMILIATE AND TO HUMBLE.

– YEHUDA BERG

? the words: denial, co-dependent

Relationship is central

Are we experienced as HARMFUL or SAFE?

Communication

The Power of Language

Judgement Awareness

Collaboration, Side by Side Partnership

Same Side of the Chess Board

Person Centered

Trauma Aware

Person centered, trauma aware care includes

- Redefine, re-perceive **all** **behavior** as strategic toward survival and adaptation to often anxiety/terror/anger provoking events or signals
- It's immediate self care – has limitations, may precipitate additional harm and risk, not adaptive to all situations
- **Admire and respect** what's brought a person to today and how they manage their day **(strengths based)**

building and keeping a strengths focus

when we talk about ourselves, clients, our team – an outlook & feedback balance

- 4 likes
- 1 wish

- BEGIN with ADMIRATION -

Key to Affirmations

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SO WHAT'S OUR CHALLENGE?

OUR CHALLENGE: Countertransference

our own beliefs, biases, and judgments (reactions)

"Sorting through our own beliefs … if we are to avoid a countertransferential mire of reflected negative judgments and basic misunderstandings of our patients."

Denning, 2000

personal triggers / our own trauma & responses

our soft spots and blind spots awareness

Being on the same side of the chess board instead of opposing

SELF-REFLECTION

A personal intimate deep challenge

Why this special work is exceptionally difficult

Recovering our own inner calm

Healing our own trauma

Knowing our own trauma responses

A word about being

non-judgmental

unconditional positive regard

unbiased

The near impossibility of this endeavor

Our brain is wired for bias.

To instead be aware of and know one's judgements

And how to account for and offset them

soft / blind spots, trauma triggers, judgements, sounds and fury

WE impact our work
WE impact healing

- We can enhance and facilitate a healing experience
- We can get in the way of and reinforce trauma, delay and confound healing

❖ **Trauma healing is restorative justice**

repairing the damage done

restoring personhood

acknowledgement
&
gratitude

this is uniquely difficult work – and must be

“This work hurts on a core fundamental level” Dr Joshua Bamberger


Permanent Housing
+
Supportive Services
=
Positive Outcomes!

Housing First

- Person Centered, Trauma Aware, **HARM REDUCTION**, Motivational Interviewing

- **Dual-Diagnosis Treatment Capable**: substance use + mental health

Housing First

- Is based on the belief that **housing is a basic human right**
- The only prerequisite for access to housing is **homelessness**
- Addresses needs from the **participant's perspective** and **values participant's choice**
- Believes that **housing provides the necessary foundation** for the process of recovery

Housing First: A Model to End Chronic Homelessness

What is Housing First?

- The Housing First model is **an approach to serving formerly chronically homeless individuals** (a group that makes up approximately 20 percent of the total homeless population) **regardless of their choice to use substances or engage in other risky behaviors**. Since 2000, the Housing First model has been widely accepted across the United States based on findings from multiple studies that demonstrated resident improvement in a number of areas.

- Pathways to Housing Inc., based in New York, is credited with developing the first Housing First program in the early 1990s. A key feature that distinguished the agency's Housing First program was that, unlike abstinence-based programs, it **did not require sobriety for individuals to be admitted to or to retain their housing.** This approach is based on **a harm reduction service philosophy** which seeks to reduce the negative consequences related to substance use (and other high-risk behaviors) rather than eliminating substance use altogether.

- The Housing First model has been endorsed by the U.S. Interagency Council on Homelessness, National Alliance to End Homelessness, and the U.S. Department of Housing and Urban Development (HUD).

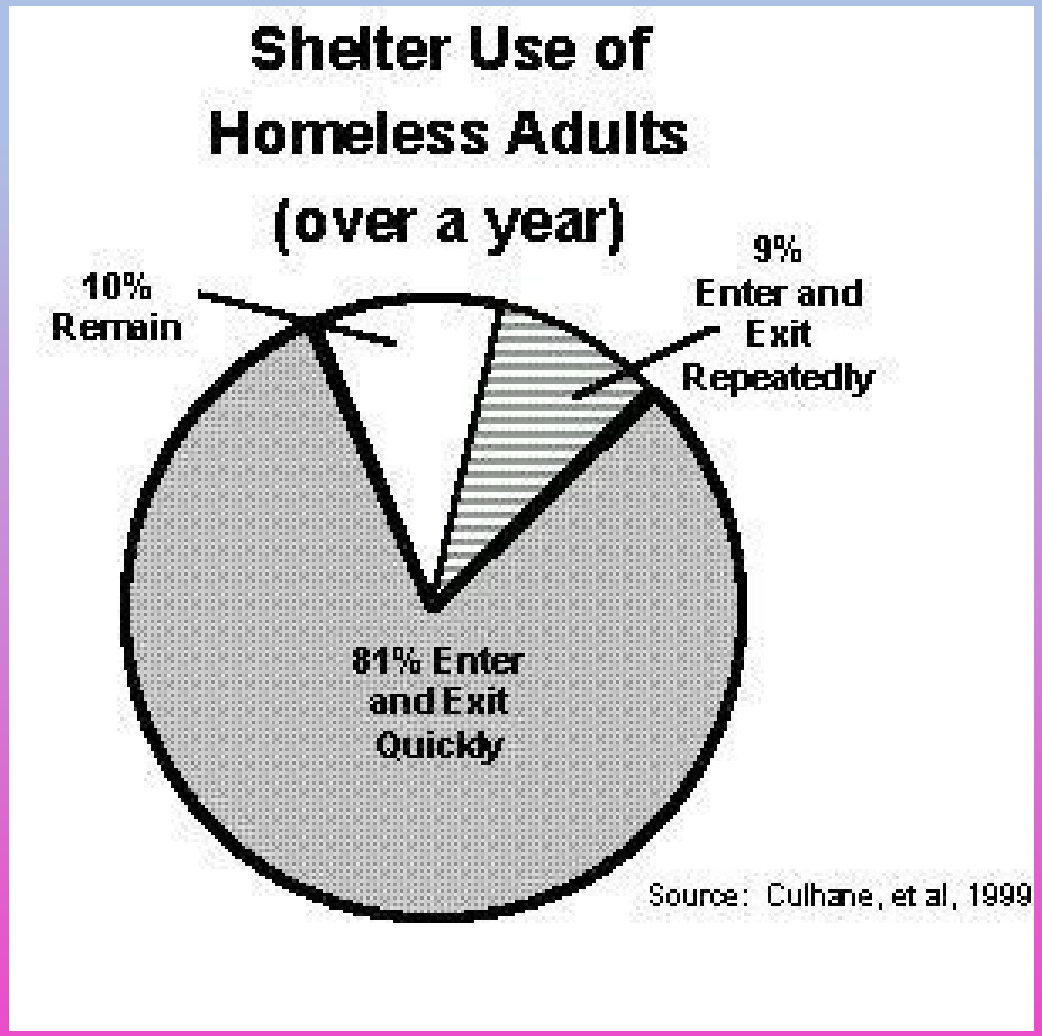
Housing First is characterized by:

- Direct placement into permanent housing
- Availability of supportive services without requirement to participate
- Use of assertive outreach to engage reluctant participants
- Approaches to ensure relapse does not result in eviction
- Continuation of housing and case management services even while participants leave for shorter time periods (HUD)

Outcomes of Housing First include:

- Reductions in problematic substance use
- Fewer emergency room visits and hospitalizations
- Higher perceived choice in services
- Reduced involvement in criminal activity
- Higher housing retention rates.

Origins of Housing First



Denver's Housing First Collaborative

Emergency Room Services	↓ by 34%
Inpatient Hospitalization	↓ by 80%
Outpatient Care	↑ by 50%
Net result to health costs	↓ by 45 %

(Perlman & Parvensky, 2006)

Massachusetts
Home & Healthy for Good Project

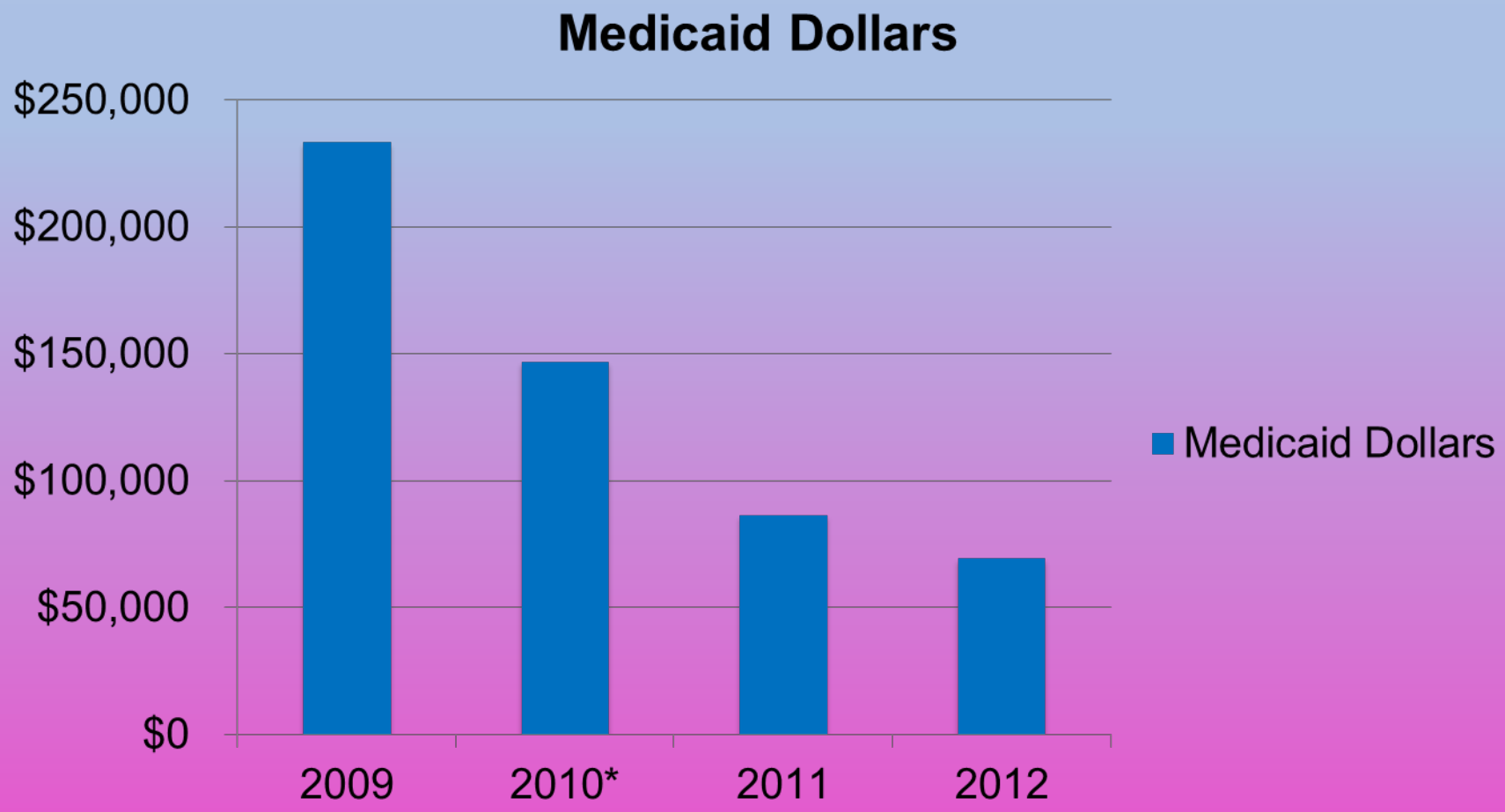
Source: http://www.mhsa.net/matriarch/MultiPiecePage.asp_Q_PageID_E_57

Chicago Housing for Health Partnership

- Reduced use of hospital system
  - Fewer hospitalizations and ER visits
- Better health outcomes
  - PLWHA were twice as likely to have undetectable levels of HIV in their blood
- Cost Savings
  - $1M saved for 100 chronically homeless housed

(Basu et al., 2011)

The Story of Carlos



*Carlos was housed in March 2010

Pathways to Housing

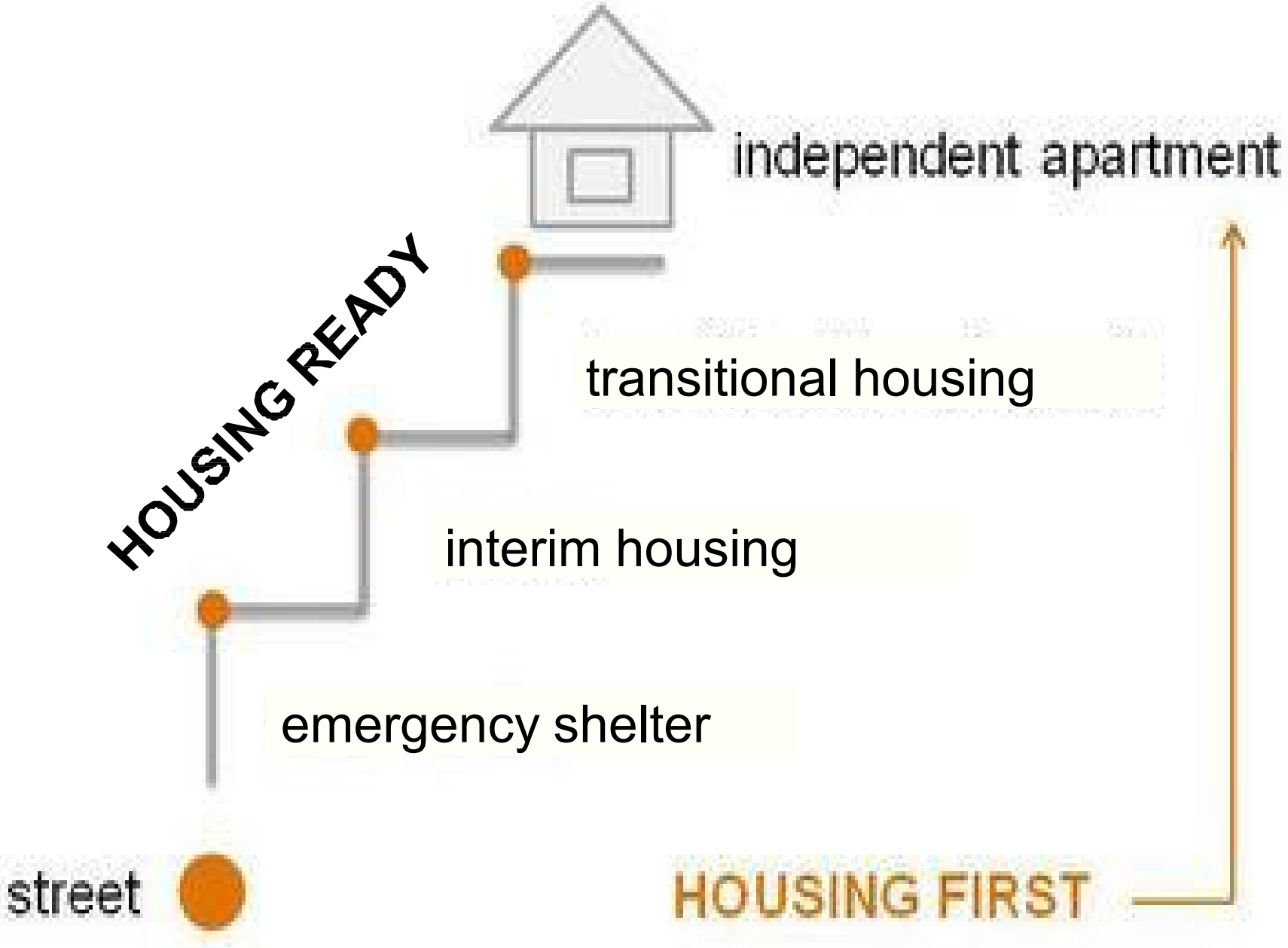
- Randomly assigned to either:
  - housing contingent on treatment participation (control)
  - housing without treatment prerequisites (experimental)
- Experimental group:
  - obtained housing earlier
  - remained stably housed at higher rates than control group
  - reported higher perceived self-determination
- Utilization of substance use treatment was significantly higher for the control group
- **BUT** no difference was found in substance use or psychiatric symptoms

(Tsemberis, 2004)

What do participants want?

- Given the choice, most participants prefer their own place in community settings
  - Creates a sense of home
  - Privacy, safety, security
  - Integrated housing
- Variety in housing and services

Adapted from webinar **Housing First:** Ending Homelessness for People with Mental Illness and Addiction www.monarchhousing.org


independent apartment
HOUSING READY
transitional housing
interim housing
emergency shelter
street
HOUSING FIRST

Essential Program Elements of Housing First:

1. Low-threshold admissions policy:

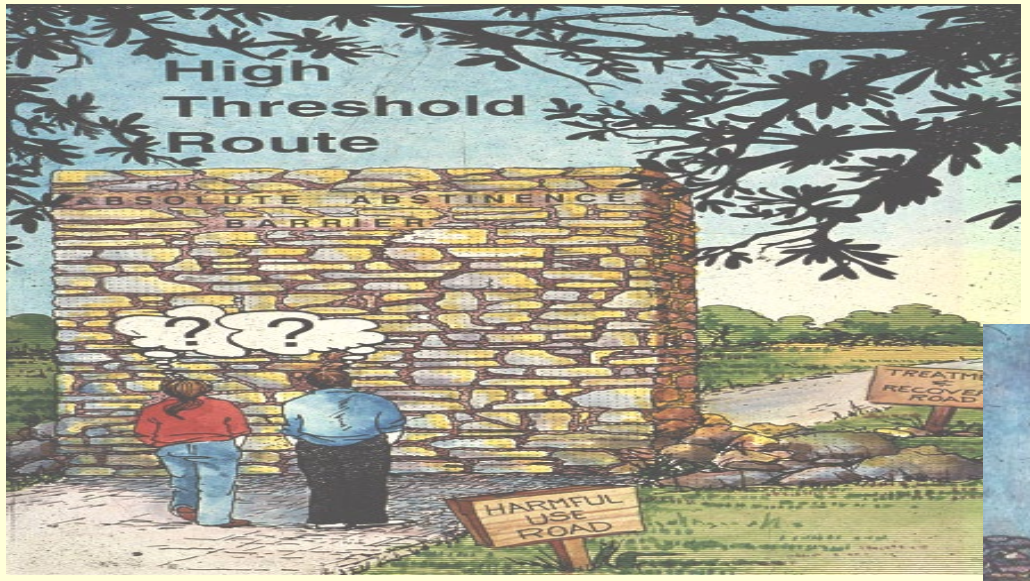
- This describes a policy that places *as few entry requirements as possible* on participants, thus *eliminating traditional barriers* to accessing housing, such as required abstinence from alcohol or other drugs or medication compliance.
- Such a policy has been recognized as providing a basis for developing *strong consumer-staff relationships* necessary for housing stability and recovery.
- Such a policy complements assertive outreach which is often used by these programs to help reach and engage the participants who are the *most vulnerable and the most alienated* from services.

2. Harm reduction-based policies and practices:

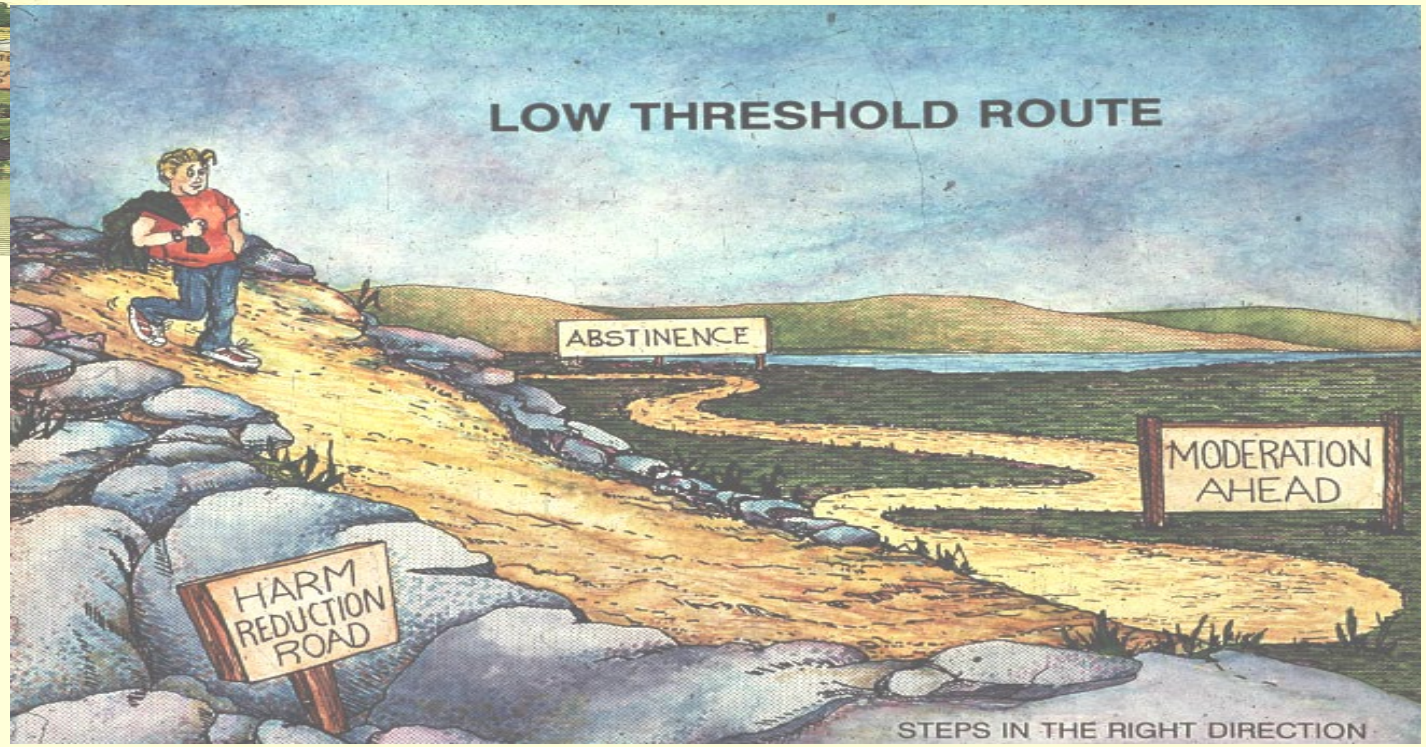
- While a low-threshold admissions policy is the mechanism that helps participants gain access to housing, harm reduction is considered the practice that is used to keep participants housed.
- Harm reduction focuses on reducing the negative consequences of high-risk behaviors, rather than eliminating them completely.
- When practiced correctly, harm reduction leads to *stronger and more honest relationships between participants and staff* and *reduces the fear and stress* related to losing one's housing due to substance use or other risky behaviors.

Trauma & Power/Control

Perceived failure may intensify desire to use



Success builds confidence, empowers, connects with inner voice



3. Separation of housing and services:

- Role definition between landlords/property management and case managers is clearly defined and separated, with case managers focusing on the role of *advocate for the participant* and landlords and property managers occupying the role of rule enforcer.
- Separation of these functions is essential for *building and preserving the relationship between case managers and participants, which serves as the basis for positive change*.

4. Reduced service requirements:

- This reflects a *strengths-based* service approach that acknowledges that *participants know what they need* and will take advantage of it if it is offered, rather than an approach that requires participation in services that may or may not be interesting or useful to participants.

inner voice, inner guide

5. Eviction prevention:

- This involves developing a plan to address behaviors that have led to lease violations and advocating with the landlord or property manager on behalf of the participant.
- Plans should focus on the problematic behavior itself (e.g. non-payment of rent, causing disruptions in common areas, etc.), especially for participants who are not interested in or ready for abstinence as a service goal.
- Plans should not focus on substance use or mental illness if those issues are the antecedents of the behavior.
- The plan should be based on realistic ways to eliminate or mitigate the problematic behavior (e.g., budgeting to ensure that rent gets paid, going directly to the apartment if intoxicated, or staying at a friend's house if intoxicated), and should be developed in conjunction with the participant.

6. Participant Education:

- Participant education about the Housing First program model and about Harm Reduction strengthens the impact of harm reduction policies and practices.
- It allows participants to attach meaning to the choices provided them and helps them to feel good about their choices and personal achievements.
- Without education, participants are likely to continue to understand the program in light of previous experiences with non-Housing First programs, believing that their housing is tenuous and so avoid interactions with staff.

inner voice, inner guide

Five Core Principles

- Immediate access to PH with no housing readiness requirements
- Participant choice & self-determination
- Recovery orientation
- Individualized & participant-driven supports
- Social & community integration

https://www.homelesshub.ca/solutions/housing-accommodation-and-supports/housing-first

Six Essential Elements

- Low threshold admissions policy
- Separation of housing and services
- Reduced service requirements
- Eviction prevention
- Consumer education
- Harm reduction-based policies & practices

(Watson & Shuman, 2013)

Low Threshold Admissions Policy

- Removes barriers to access housing
  - Ongoing substance use
  - Lack of engagement in health care or mental health treatment
  - Lack of income
  - Credit, rental history
  - Criminal background

"We should work to try and get people housing regardless of what they come to us with." –Housing First Staff

Separating Services and Eviction

Use different criteria for success in housing and in services

- Substance use and mental health symptoms are anticipated and not a housing problem
- Substance use or psychiatric symptoms ≠ eviction
- Eviction ≠ discharge from program

Our commitment is to the person

not the housing

Adapted from webinar **Housing First:** Ending Homelessness for People with Mental Illness and Addiction www.monarchhousing.org

Landlords as Partners

Landlord, program, and participants all have

a common goal:

All want safe, decent, well managed housing.

How can we work together to avoid eviction?

Adapted from webinar **Housing First:** Ending Homelessness for People with Mental Illness and Addiction www.monarchhousing.org

Consumer Education

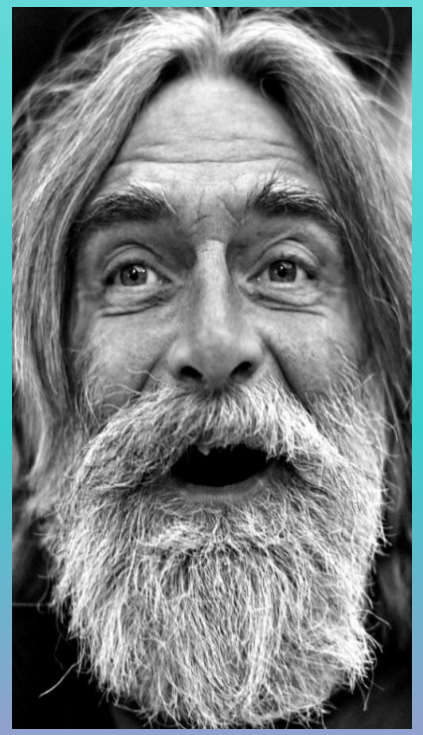
- Staff and consumers need time to adjust to this new approach
- Everyone should have access to ongoing training and resources
- How do we explain HFM to participants?

Typology of Programs

	Consumer Education	
Program Flexibility	High	Low
High	*Empowerment*	*Enabling*
Low	*Treatment*	*Alienating*

(Watson, 2012)

Consumer Education



…[I]t was shortly after one of our one-on-one sessions where [my case manager] said…"You realize your housing is not contingent on you being abstinent?". And I hadn't realized that at that point…[T]hen things started to change. I started working real close with them, being honest with them.

– Housing First Consumer

Why Harm Reduction?

- If Housing First is to succeed, substance use can no longer be a barrier to accessing housing
- Homeless individuals with substance use problems must be offered the same options and rights as other people who are homeless
- **Homelessness is not a cure for addiction**

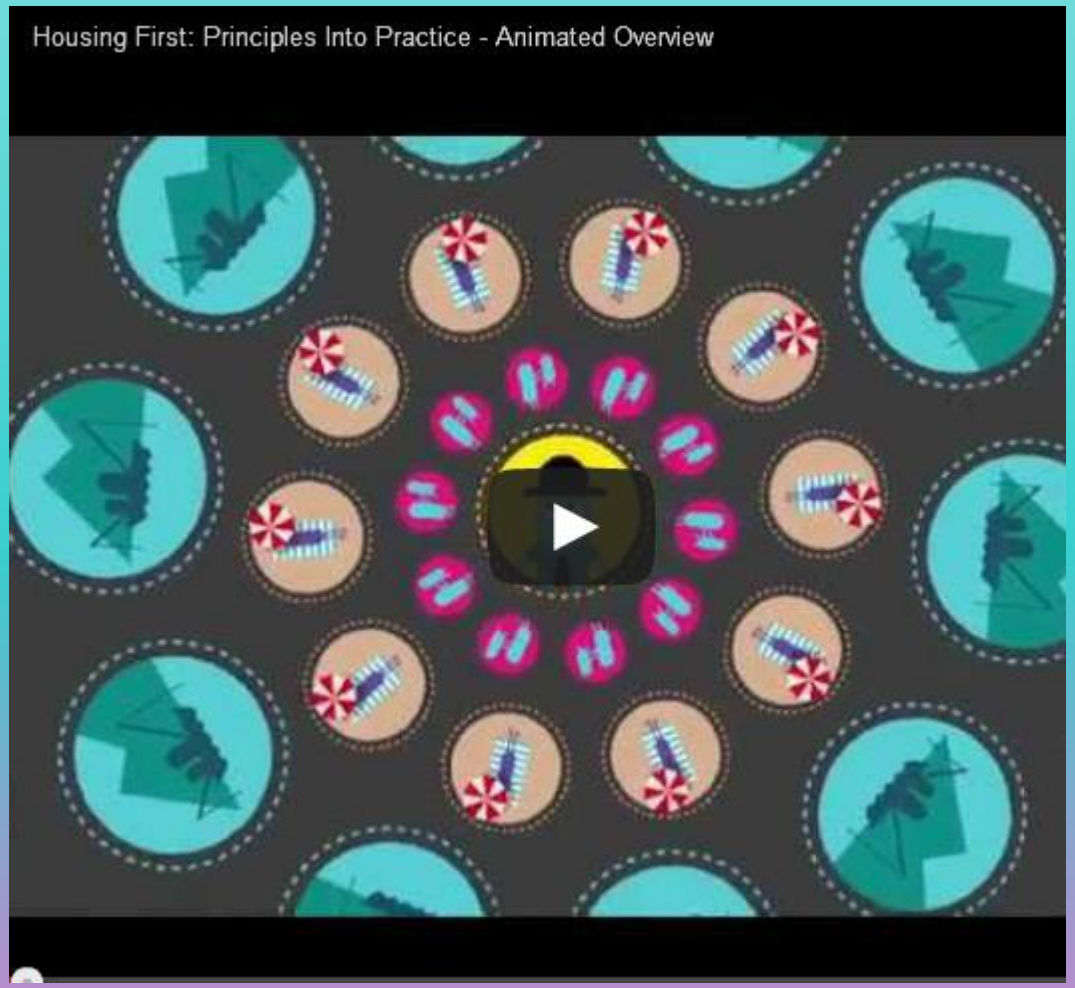
Housing First Checklist (USICH, 2016)

Core Elements of Housing First at the Program/Project Level

- ☐ Services are informed by a harm-reduction philosophy that recognizes that drug and alcohol use and addiction are a part of some tenants' lives. Tenants are engaged in non-judgmental communication regarding drug and alcohol use and are offered education regarding how to avoid risky behaviors and engage in safer practices.
- ☐ Substance use in and of itself, without other lease violations, is not considered a reason for eviction.

Full list available at …
https://www.usich.gov/resources/uploads/asset_library/Housing_First_Checklist_FINAL.pdf

Housing First Principles



https://www.youtube.com/playlist?list=PLn2dcn1mdW4oAhzNDrCrI0AGx11FJ_ukC

Midwest Harm Reduction Institute

Common Challenges

- Excessive visitors, a lot of in and out traffic
- Noise complaints, knocking on doors
- Hygiene and cleanliness of unit, hoarding
- Non-payment of rent, budgeting
- Being taken advantage of (loaning money, non-participants taking over a unit)
- Intoxication
- Billing requirements

Other Considerations

- Fixed Site vs. Scattered Site
- Community relationships: police and other emergency services, local businesses
- Transitional options
- Access to neighborhoods that are safe and have access to transit, food resources, and other services
- Quality of life and meaningful activities
- Overdose prevention, naloxone access

Questions and Concerns

HOUSING FIRST FIDELITY INDEX (HFFI) MEASURES

Dennis Watson, Valery Shuman

HOUSING FIRST FIDELITY INDEX (HFFI) FIELDS

PROGRAM INFORMATION

HUMAN RESOURCES STRUCTURE and COMPOSITION
PROGRAM BOUNDARIES
FLEXIBLE PROGRAM POLICIES
NATURE OF SOCIAL SERVICES
NATURE OF HOUSING and HOUSING SERVICES

HOUSING TYPE

PROGRAM INFORMATION

- **Housing Retention data**
- **Program specific** only (not entire organization) and from **whose perspective** (Executive Leader, Program Director/Manager, Supervisor, Direct Service Clinical Staff)?
- **Staff** present as *client support staff** only OR staff who work on *client support* issues related to housing (eviction prevention, rent issues)?

  * *"case managers"*

  - Provided directly *OR* contracted out?
- **Funded units** of this program – on location or multiple locations?

HUMAN RESOURCES STRUCTURE & COMPOSITION

1. **Minimum Education Requirements** – at least 1 CM or direct supervisor with a MA or higher
2. **Crisis Intervention & Harm Reduction Knowledge** – requires ongoing training in HR and crisis intervention for staff
3. **Clinical Staffing** – have psychiatric staff and MHP on staff or contracted with

PROGRAM BOUNDARIES

1. **People Served** – solely individuals experiencing chronic homelessness and having a dual dx, and allows individuals currently using
2. **Outreach** – designated staff responsible for outreach
3. **Termination Guidelines** – only terminates residents who demonstrate violence, threats of violence, or excessive non-payment of rent

FLEXIBLE PROGRAM POLICIES

1. **Admissions Policy** – formal protocol for admitting individuals with the greatest need/vulnerability
   a. First come first served basis
   b. Assessed need vulnerability basis
   c. Combination of the two
   d. Within Coordinated Entry System
2. **Benefit/Income Policy** – possession of or eligibility for income benefits is not a prerequisite for housing
3. **Individual Choice in Housing Location** – program works with individuals to find desirable housing
   a. Initial, relocation, discharge planning
4. **Housing Relocation** – always attempts to relocate residents when they are dissatisfied with their current housing placement

FLEXIBLE PROGRAM POLICIES

5. **Unit Holding & Case Management Continuation** – holds housing for hospitalization and incarceration for more than 30 days and program continues to offer CM services while unit is unoccupied
6. **Missed Rent Payments** – flexible with missed rent payments, and holds resident accountable
   a. How many months missed payments/service fees before termination/discharge/eviction?
   b. Rep payeeship?
   c. Payment plan for back rent?
   d. Re-house after eviction if by landlord?

FLEXIBLE PROGRAM POLICIES

7. **Alcohol Use Policy** – allows alcohol use and housing allows alcohol units
8. **Drug Use Policy** – allows illicit drug use and housing allows illicit drug use in units
   - *Who holds lease? Master lease option?*
9. **Eviction Prevention** – formal policy and protocol to work with resident to prevent eviction, and has a staff member dedicated to eviction prevention
10. **Resident Input Into Program** – formal and informal mechanisms for receiving and implementing resident input
    - Formal program evaluation, quality assurance activities, concerns explicitly addressed, suggestions boxes, community meetings

NATURE OF SOCIAL SERVICES

1. **Service Approach** – residents are not requires to engage in any services except for CM to receive/continue receiving housing
2. **Harm Reduction Approach** to Service Provision – uses a HR approach and staff has a strong conceptual understanding
3. **Regular In-Person CM Meetings** – 2 to 3 per month, but more frequent meetings in first 1 to 6 months
4. **Small Staff-Resident Partnerships** – CM have 10 or fewer residents partnership
5. **Ongoing Resident Education** – ongoing resident education in Housing First and HR

NATURE OF HOUSING AND HOUSING SERVICES

1. **Structure of Housing and Services** – housing is scattered-site in building operated by private landlords
2. **Rapid Placement into Permanent Housing** – places individuals into housing in one week or less
3. **Temporary Housing Placement** – TH placement does not last more than a month

HOUSING TYPE

1. Would you identify this program as a HF program?
    a. If no, would you consider your program to run under the HF principles?
    b. For how many years?
2. How many years has the program operated under the principles of HF?
3. On a scale from 1 – not at all satisfied to 5 – very satisfied, how satisfied would you say you are with HF as an approach to housing?
4. Past year data includes numbers served, duration of those individuals in program, and numbers left program and reasons
5. Indications of higher level of functioning or resources (‘creaming’)?
6. HF principles but abstinence based approach to substance use?

DUAL DIAGNOSIS TREATMENT CAPABLE

MENTAL HEALTH + SUBSTANCE USE

CONSULTATION. COLLABORATION. INTEGRATION.

ILLINOIS CO-OCCURRING CENTER FOR EXCELLENCE

- **POLICY**
  - Program Structure
  - Program Milieu
- **CLINICAL PRACTICE**
  - Assessment
  - Treatment
  - Continuity of Care
- **WORKFORCE**
  - Staffing
  - Trainings

POLICY Program Structure

- **Mission Statement** – primary focus on people with CODs
- **Certification & Licensure** – to provide both MH & SU tx
- **Coordination and collaboration** with MH or SU services – integrated with program structure
- **Financial incentives** – can bill for both

POLICY Program Milieu

- **Routine welcome and expectation for both** – regardless severity, all tx well documented
- **Display and distribution** of literature & participant educational materials – routinely, equivalently available for both, interrelated nature of COD

CLINICAL PRACTICE Assessment

- **Routine screening methods** – standardized, formal instruments with psychometric properties for both
- **Routine assessment if screened positive** – assessment formal, standardized and integrated for COD and well documented
- **MH & SU dx made and documented** – comprehensive dx services provided in timely manner and well documented
- **MH & SU hx reflected in EMR** – specific sections devoted to hx and chronology of both and interaction between is examined

CLINICAL PRACTICE Assessment

- **Program acceptance** – admits with moderate to high acuity including unstable in either
- **Program acceptance** – admits with moderate to high severity and persistence in either
- **Stage-wise assessment** – formal measure used for both, and well documented

CLINICAL PRACTICE Treatment

- **Tx Plans** – routinely address both equivalently, in specific detail; interventions, harm reduction, medications used
- **Assess and monitor interactive course** of COD – tx monitoring and documentation routinely reflects clear, detailed, systematic focus on change in both
- **Procedures for emergencies and crisis management** – routine capability with a process to ascertain risk of both; maintain in program unless alternate placement (hospital, detox) is necessary
- **Stage-wise treatment** – stage of change or motivation routinely incorporated into individualized plan; formally prescribed and delivered stage-wise tx for both

CLINICAL PRACTICE Treatment

- **Policies & procedures for medication** evaluation, management, monitoring, and adherence – clear standards and routine for med prescriber who is also a staff member; full access to prescriber and guidelines for prescribing in place; the prescriber is on the tx team and the entire team can assist with monitoring.
- **Specialized interventions** with content for both – routine sx management groups; individual focused therapies for both; systemic adaptation of an EBP (MI, HR, CBT, 12 Step …).
- **Education material** about both, tx and interaction of CODs – specific content for each routinely offered in individual and group formats

CLINICAL PRACTICE Treatment

- **Family education** – routine and systematic COD family group integrated into standard program format; accessed by families of the majority of participants with CODs.
- **Specialized interventions to facilitate use of peer support groups** in planning or during tx – routine facilitation targeting specific COD needs, intended to engage participant in MH, SU, or COD peer support groups.
- **Availability of peer recovery supports** for patients with COD – on site, facilitated and integrated into program; routinely utilized and documented with COD focus

CLINICAL PRACTICE Continuity of Care

- **COD addressed in discharge planning process** – both seen as primary, with confirmed plans for on-site follow-up or documented arrangements for off-site follow-up, no less than 80% of the time
- **Capacity to maintain tx continuity** – formal protocol to manage MH and SU needs indefinitely and consistent documentation this is routinely practiced typically within the same program/organization.
- **Focus on ongoing recovery issues for both** – routine focus on recovery and management with both seen as primary and ongoing.

CLINICAL PRACTICE Continuity of Care

- **Specialized interventions to facilitate use of community based peer support groups during d/c planning** – assertive linkage and interventions routinely made targeting specific COD needs to facilitate use of SU, or COD peer support groups.
- **Sufficient supply and adherence plan for medications** is documented – maintains med management in program with provider.

WORFORCE Staffing

- **Psychiatrist or other physician or prescriber** of psychotropic/MAT meds – staff member, present on site for clinical, supervision, tx team, and/or admin.
- **On-site clinical staff with licensure/certification**, graduate degree, or competency, substantive experience – 50% or more clinical staff have either license or substantial experience sufficient to establish competence in COD tx
- **Access to COD clinical supervision or consultation** – routinely provided on site by staff member and focuses on in-depth learning.

WORFORCE Staffing

- **Client review, staffing, or UR procedures** emphasize and support COD tx – documented, routine, and systematic coverage of COD
- **Peer/Alumni supports are available with COD** – available on-site with COD, either as paid staff, volunteers, or program alumni. Routine referral made.

WORFORCE Training

- **All staff have basic training** in attitudes, prevalence, common signs, and sx detection and triage for COD – most staff trained and periodically monitored by agency strategic plan (80% or more staff trained).
- **Clinical staff have advance specialized training** in integrated psychosocial or pharmacological tx of persons with COD – most staff trained and periodically monitored by agency strategic training plan (80%or more clinical staff trained).

DuDx CAPABLE TREATMENT EVIDENCED IN …

- Policy & Procedures
- Electronic Medical Record (EMR)
- Website
- Flyers, brochures, handbooks
- Curricula
- Interviews with program director, clinical staff, program participants
- Site tour

Questions and Concerns

Additional Resources:

- Housing First Practice Community
  http://housingfirstpracticecommunity.weebly.com/
- Pathways to Housing
  www.pathwaystohousing.org
- Downtown Emergency Service Center (DESC)
  www.desc.org
- National Alliance to End Homelessness
  http://www.endhomelessness.org/pages/housing_first
- USICH Housing First Checklist
  https://www.usich.gov/resources/uploads/asset_library/Housing_First_Checklist_FINAL.pdf
- Housing First in Permanent Supportive Housing Brief (HUD)
  https://www.hudexchange.info/resources/documents/Housing-First-Permanent-Supportive-Housing-Brief.pdf
- Canadian Housing First Toolkit
  http://www.housingfirsttoolkit.ca/

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Additional Reading

Housing First Practice Community—Blog includes articles on harm reduction, website also has discussion forums and toolbox for Housing First providers
http://housingfirstpracticecommunity.weebly.com/blog

"Starting Where the Client Is: Harm Reduction Guidelines for Clinical Social Work Practice" by Sheila Vakharia and Jeannie Little
https://www.researchgate.net/publication/301343562_Starting_Where_the_Client_Is_Harm_Reduction_Guidelines_for_Clinical_Social_Work_Practice

"What's Under the Harm Reduction Umbrella?" by Jeannie Little
https://www.thefix.com/content/under-harm-reduction-therapy-umbrella-part-1

Web Resources

Reflection and Support for Staff

- T3 Changing the Conversation podcast:
  - http://us.thinkt3.com/podcast
- Coldspring Center Blog:
  - http://coldspringcenter.org/mattsmumblings/

Harm Reduction Advocacy

- Drug Policy Alliance
  www.drugpolicy.org
- Harm Reduction Coalition
  - www.harmreduction.org

Harm Reduction Therapy

- Center for Optimal Living
  - http://centerforoptimalliving.com/
- Harm Reduction Therapy Center
  - www.harmreductiontherapy.org

Harm Reduction Outreach and Resources

- Chicago Recovery Alliance
  - www.Anypositivechange.org
- Sex Workers Outreach Project
  - http://www.swopusa.org/

Peer Support Groups

- Harm Reduction, Abstinence, Moderation Support (HAMS)
  - www.hamsnetwork.org
- Moderation Management
  - www.moderation.org
- SMART Recovery
  - www.smartrecovery.org

Drug Education

- Erowid
  - www.erowid.org
- Blue Light Drug Forums
  - www.bluelight.org
- Guide to Drug Combinations
  - https://wiki.tripsit.me/wiki/Drug_combinations
- Worldwide Drug Survey
  - http://www.globaldrugsurvey.com/brand/the-highway-code/
- Drugs Meter: https://www.drugsmeter.com/
- Drinks Meter: http://www.drinksmeter.com/app/

Housing First Principles

https://www.youtube.com/playlist?list=PLn2dcn1mdW4oAhzNDrCrI0AGx11FJ_ukC

Midwest Harm Reduction Institute


Thank you!
MBK Associates

for follow up & additional information …

Tom Kinley | Field Support & Systems Change Facilitation
Pronouns: he/him/his
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